

HEALTH SELF-CARE AND THE USE OF MEDICINAL PLANTS IN THE FAMILY CONTEXT OF STUDENTS¹

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ABSTRACT

The objective of this study was to identify health self-care actions adopted in the family context of students, from the urban and rural environment, and their relationship with medicinal plants. It consisted of a qualitative exploratory research, based on the Self-Care reference. Data were collected between January and July, 2014, through a semi-structured interview recorded at the home of the relatives of students. The analysis was carried out through the Operative Proposal, emerging the themes: Health care in comprehensive self-care actions and Care in disease prevention in restricted self-care actions. The results point to the constant articulation between the forms of broad and restricted self-care in urban and rural environments, including medicinal plants, self-medication, symptom surveillance and health unit consultations. This constant dialogue reaffirms that self-care includes several interconnected care, not excluding any type, demonstrating that the population does not deny one by using the other, but constantly articulates practices. However, health professionals are not acting in an articulated way, which is perceived by the population. Therefore, these professionals need to consider care cultural practices, promoting health in an integral and articulated way.

Keywords: Family. Family relations. Health care. Culture. School health.

INTRODUCTION

Health can be considered as an unpredictable event of individuals, marked by the high degree of subjectivity in people's relationships and actions. This subjectivity brings an imaginary, fruit of social practices and representations that reflect the culture and the way of perceiving health and disease. However, these aspects are invisible in the eyes of positivist rationality, and consequently, of health professionals⁽¹⁾.

Currently, these professionals still reproduce positivism, imposing a closed theoretical model, in which the health service user does not actively participate in its own health and/or disease process. This may be due to the dynamics of health services, lack of capacity or lack of interest in the user⁽²⁾.

At the same time, an important perspective that produces criticism and approximation with the reality of the population comes from anthropology. This knowledge area assists in the understanding that the biomedical system is one of the health care models, not the only one. As we approach the population, whether

during health care or through researches, it is possible to examine specificities of care practices with these social groups, valuing cultural aspects, knowing different forms of health care, understanding that there are several rationalities and care systems.

Adopting this anthropological view on health allows establishing meaningful relationships focusing on understanding the other's behavior and thinking, based on personal and cultural perspectives⁽³⁾.

The Menéndez' Self-Care reference^(4,5) understands that the population travels through several forms of health care, the biomedical one, which comprises the official health system; the popular and traditional one, which includes informal professionals, such as healers, spiritualists, among others. There is also the "new age" type, which includes new community religions based on healing; the derivative of other medical traditions, such as acupuncture; and the one centered on self-help, as groups of anonymous alcoholics, among others⁽⁴⁾.

Thus, in order to understand different care practices, this study is anchored in this framework. Self-Care⁽⁴⁾ refers to representations and practical

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experiences that people use to control, facilitate, support, cure or avoid processes that affect their health, in real or imagined terms, without the direct intervention of professionals, although they may refer to this activity. It involves deciding in an autonomous way, the way people act in the search for health.

Self-care can be divided into two levels, the broad one and the restricted one. The broader level would be the actions established by the culture of the person and the group, especially in the family context. The restricted level refers to the intentional practices applied to the health/illness/care process⁽⁶⁾.

In order to meet the population's health needs, in view of the different social contexts, since de 1970s, the World Health Organization (WHO) has guided the inclusion of the traditional medicine in the care system. At the same time, alternative or complementary practices have been increasing, in both the broad as restricted self-care, which, in a way, may be a reaction to characteristics of the biomedical model, but this may not be the deciding factor⁽⁶⁾.

Several factors can influence the use of these therapies, such as easy access, low cost, credibility in their effectiveness, among others. An example of this is the use of medicinal plants, which are of great importance for the maintenance of health conditions. Besides proving the therapeutic action of many plants used popularly, the plants represent an important part of the population's culture, being spread throughout the family generations^(7, 8).

Therefore, the family is an important part of the different types of health care systems. In addition to the family, another environment becomes especially favorable to the formation of appropriate citizens over the various health-seeking options is the school. This place is a possibility to form a future population of emancipated, citizens and autonomous adults⁽⁹⁾.

Furthermore, in the face of so many changes in the urban and rural contexts⁽¹⁰⁾, it becomes relevant to know the family's self-care actions, which includes the school context, in both places. In this way, health professionals can, from the knowledge of the health self-care actions in the urban and rural environments, widen their gaze and, with this, provide an assistance in the intention of integrality, which takes into account and knows the population's reality.

As assumptions, the students' family is a form of self-care reference that may include care with medicinal plants, possibly being more present in the rural area than the urban one, not necessarily occurring at a specific moment, but through family coexistence.

In this perspective, the objective of the research is to know health self-care actions adopted in the family context of urban and rural students, and their relationship with medicinal plants.

METHODOLOGY

A qualitative study of the exploratory type, carried out at the participants' home, in the urban and rural area of the city of Pelotas (RS), near two schools.

The participants were 12 families of students who are attending the 5th, 6th and 7th grade. In order to select the students who would be part of the research, the following criteria were used: attending the pre-established classes (5th, 6th and 7th grades); having responded using medicinal plants in the largest survey data collection instrument and having provided telephone number. From this, the respective families with the criteria of residing in a place of easy terrestrial access and close to the school were selected.

The classes from the 5th, 6th and 7th grades were selected for considering that these students are in a life stage when a transition occurs, characterized by the fact that they carry family values, and begin to acquire new values, associated with the groups surrounding them, like the school. In this way, the researchers considered important to investigate, at this life stage, their perception about care and self-care practices, including the family influences and medicinal plants.

For the data collection, the database of the Project "*Use of medicinal plants and popular health practices among students from a municipality of Rio Grande do Sul*" specific to the answer of the question "Do you use medicinal plants?" was consulted. All families of students who answered positively to this question were contacted, explaining the reason for the contact and if there was interest in participating in the research. After accepting, a home visit was scheduled. Semi-structured interviews were recorded from January to July 2014.

The information was analyzed following the Operative Proposal⁽¹¹⁾ and in accordance with the Menéndez' Self-care framework⁽⁴⁾, through two moments. The first was the research exploratory phase, which refers to the socio-historical context of the social group in question. The second moment, called the interpretative moment, occurred through the ordering of the empirical data, the classification of these data and the final analysis. The topics from the analysis will be addressed in this article.

The Research Ethics Committee approved the research, protocol 223/2011. Participants signed the

Informed Consent Form in two copies. In order to preserve anonymity, their reports are identified by the kinship relation with the student, followed by age and locality - urban or rural.

RESULTS AND DISCUSSION

Twelve family members of students were approached, six from the urban area and six from the rural area. Regarding the students' relatives, six are mothers, three grandmothers, two fathers and one stepfather. These relatives were willing to receive the researcher at home. In this way, nine out of the twelve family members are women. Their ages ranged from 31 to 62 years old. Among them, seven have incomplete elementary education, two complete elementary education, one complete secondary education, and one incomplete college, showing a low level of schooling, regardless of the place where they are inserted. All residences were located near the Basic Health Unit (BHU) and the school.

Health care in comprehensive self-care actions

Social, cultural and economic aspects directly influence the decision-making in relation to the health-disease process of the population, as well as the path to follow in order to achieve a better quality of life⁽¹²⁾. In this sense, the participants of this study, despite their urban and rural particularities, demonstrated to carry out broad actions of self-care in their family care system.

Some of these broad self-care actions relate to family care, such as the hygiene of the environment, as the following speeches show:

It is more about prevention itself. Housekeeping, not leaving the house too closed, open, let the sunlight in, put these things on the street in the sun (Mother, 42, rural).

First, a well-ventilated house, not keeping the house too closed, not having the house closed with several people, which complicates things a little, right (Mother, 54, urban).

Housekeeping, such as keeping it airy and with access to sunlight, characterizes effective activities from various perspectives. These actions can reveal multiple meanings for the participants, such as the hygiene of the environment and objects, the space energization, air circulation, balance, among others. From a biological perspective, these actions can increase humidity inside the house, which can be harmful, since the humidity can cause several diseases,

especially related to the respiratory system. This is aggravated in places with high relative humidity, such as the municipality where this study was carried out, where the relative

humidity annual average is about 80%⁽¹³⁾.

In addition to housekeeping, participants reported self-care actions related to organic and biological balance:

A good diet, balanced, natural things. We have [planted], we have the vegetable garden, fruits (Father, 62, rural). Not walking barefoot, not walking in the rain (Mother, 42, urban).

Another thing is hot food, she really likes hot food, and in all meals, I am always saying [student's name] do not eat hot food, it hurts (Grandmother, 55, rural).

These discourses refer to the reflection that the anthropological logic of hot/cold is still present in current societies. This logic relates health or disease needs to biological and/or social imbalance. In addition, she understands that there is a differentiated therapeutic process for the different needs, in which hot diseases, for example, should be treated with medicinal plants or cold foods^(14,15).

Despite recognizing these important actions for the health maintenance, such as nutrition, several peculiarities involve not doing what one believes is the best. In both studied populations, quantity is, in some cases, more prized than quality, considering quality the perspective of prioritizing nutritious foods. However, the vulnerability in several factors, especially economic ones, directly interferes in the accomplishment of these actions.

Food when we can, we improve, but when we cannot, we eat rice and beans. Even because the vegetables are more expensive than rice and beans. (Mother, 42, rural).

Previously, we ate a lot more vegetables because they were very much cheaper vegetables, but, unfortunately, sometimes, if they are expensive, I end up failing to buy them (Mother, 38, urban).

These speeches make us think about the conditions faced by the population to effectively have health. In this sense, it is important to reflect that, nowadays, there is a great deal of concern about access to health care and quality care - indisputably important. On the other hand, it is necessary to think about the basis of the different social strata, as to the minimum necessary to produce health, such as nutrition.

Moreover, this fact occurs even in the rural environment, since many people do not have planting and cultivation of food and do not have easy access in

the community to the local production, as observed in the following report:

The people around us, many of them do not plant, and those who do it, directly delivery in the city [...]. There is no planting because our soil here [...] I have already tried it, it is very low, the water takes all good soil away, and only the bad soil was left, it only has fruit trees, these things, but planting a vegetable garden is very difficult (Mother, 42, rural).

This situation demonstrates that, although the participant resides in the rural area, there is a distancing of knowledge about soil conditions, cultivation, and plant management and food production, and lack of knowledge represents, in this case, an obstacle to diversify food and qualify life conditions.

The exposed speeches show broad self-care actions that come from the empirical knowledge, without the direct intervention of health professionals, performed in the domestic scope. However, there are also broad actions of self-care influenced by the biomedical model, which generally involve prevention actions.

She [wife] has to do follow-up, right, and pre-cancer issue, these things. I have been performing routine exams (Father, 62, rural).

We go to the health centers, right now I performed the pre-cancer. Now, I only have to perform the breast examination, we have to do (Grandmother, 52, urban).

Therefore, it is necessary to accept and recognize that there are several forms of attention, which can vary from the biomedical model to popular knowledge. However, when considering these actions in the search for health - especially by health professionals, the conception of antagonism between them is usually used, instead of transactional links between the different forms of attention. In social groups, this occurs in a natural way, in which they incorporate different forms of care, without antagonizing them, or denying the role of others, since they travel in all ways, often using them concomitantly⁽⁶⁻¹⁶⁾.

In addition to the presented speeches, which demonstrated the broad self-care actions, related to care with the home, the body, the biomedical model, among others, one participant stood out for reporting not performing activities to have or maintain health:

I, precariously nothing, because I smoke too much. It is true, I smoke too much, one cigarette pack per day, I mean, I do not do anything to keep my health, well [...] If we eat, only at night, we eat all night, and, during the daytime, we sleep, and then we get up late and start

eating again. We only live to eat and sleep [...] I do not stay healthy, I smoke, I drink chimarrão, [...] I am addicted to chimarrão and cigarette, not to keep it (Grandmother, 59, urban).

Nevertheless, this participant reported using medicinal plants frequently and taking appropriate care of them, such as not having home planting since she has dogs at home, not using plants that are toxic when ingested by oral route. In addition, she is careful with her nutrition, such as not ingesting too much salt and sugar, or fatty meat, although she did not recognize it as an action to have or maintain health, as observed in the following speech:

I do not even like salt and sugar [...] fat either, we do not eat fatty meat or anything, I really like chicken, fish (Grandmother, 59, urban).

This speech highlights the importance of the health professional to investigate and value self-care actions performed in the family environment, however small they may seem to the individual, encouraging the family to keep them, since they represent part of the culture. Regarding actions that may be detrimental to health, the professional needs to guide in a dialogical way.

Knowing and valuing self-care actions can be a way to go beyond the biomedical model, stop seeing only the disease, the patient, and starting to see in a way that values culture and practices in the search for health performed by the population.

Disease prevention care in restricted self-care actions

Restricted self-care actions refer to intentional practices applied to the health/illness/care process⁽⁶⁾. In this sense, the participants were questioned about their actions in situations of illness or health needs. They mentioned different activities, such as those related to domestic actions, the biomedical model, and to the use of medicinal plants.

Among the domestic activities, the following speeches exemplify some actions:

If I see that the child is not well, that there is something different then I take the thermometer and measure the temperature [...] if it was thirty-eight I give a few drops of paracetamol according to the weight. If the fever is too high and I cannot bring it down with a tea or medicine [...] in the morning, we go to the health center (Father, 47, rural).

Ah, my first option is the tea [...] I give an anti-fever tablet, I give a paracetamol, a droplet of dipyrone, then I

go [...]I always, with all my children, start the treatment, then I take them to the doctor (Mother, 54, urban).

These actions demonstrate the autonomy of the population in health care and disease. Corroborating this statement, some participants reported a preference for the use of medicinal plants, which is often the first option when faced with a health or disease need.

Go there, make a cup of tea, and take it, it is better than taking the medicine. Medication arranges one thing and spoils another (Mother, 42, rural).

Because I would rather using tea than using a medication (Mother, 38, urban).

Popular practices represent an important way to deal with the health and disease process. People often decide the kind of care they will carry out, based on shared referrals by people who live and interact, using different types of actions to have or maintain their health, influenced by cultural values⁽¹⁷⁾.

However, it becomes increasingly necessary to consider factors that involve the use of medicinal plants. Although the use of "teas" - as the participants point out - is something usually performed at home, usually without the participation of health professionals, they need to know the various factors that involve the use of medicinal plants, such as their benefits, the possible toxic effects, the correct harvest, the adequate preparation, among others. In addition, the fact that there are no plants at home and buying them involves other risks, such as contamination and adulteration of medicinal plants.

Furthermore, several factors interfere with the effect of a medicinal plant. Most of the time, popular knowledge is passed on, without considering that the plant's active principle varies according to, for example, biodiversity, genetic code, climatic conditions, seasonal changes, luminosity, water table and soil conditions⁽¹⁸⁾. This fact, by changing some properties of the plant, also changes the effect on the organism.

The participants' speeches show that, despite the belief that medicinal plants are easily accessible to the entire population, this is not the reality of all:

We do not [buy], we have a lot in the woods (Mother 42, rural).

We go out there in the woods and find a lot of it (Mother, 31, rural).

No, I do not have [medicinal plants planted], because we have no space here. It is generally a box of tea, we have boxes of tea, a two or three boxes (Stepfather, 47, urban)

I buy boxes of tea. I also buy with the herbalist

(Grandmother, 59, urban)

There is a strong relationship, in terms of access to medicinal plants, with the place where the participant resides. The aforementioned discourses show that, in rural areas, there is still greater access to medicinal plants compared to urban areas.

In the context of restricted self-care, the use of medicinal plants occurs in the face of a health need, especially those that the participants refer to as "mild cases", such as colds, stomach pain, among others, where the focus is to relieve the symptoms. With this, this can be a way to "medicalize" medicinal plants, where there is only the exchange of one type of "medication" for another more natural.

In case of influenza, we already have a selection of some, when it is a pain in the stomach, we have others (Father, 47, rural).

It is an alternative thing, to get rid of headache, flu, cold, these things (Grandmother, 59, urban).

Another reality highlighted by the participants is the lack of knowledge of health professionals about medicinal plants, especially physicians, as can be seen in the following discourse:

Because you know that doctor likes to prescribe, no use, doctor is the medicine base right, they do not believe in tea (Mother, 38, urban).

When medicine turns its attention to popular practices, it is usually in the sense of ownership interest. The biomedical model has been continuously expanding on popular practices in a way that these are subaltern, appropriating these forms of attention, including in their technical and ideological rationality. An example of this is the case of the appropriation of acupuncture⁽¹⁹⁾.

This further reinforces the need to know the different practices performed in the family care system. This is not a current need, once, since the 1950s, different trends in psychology, sociology, anthropology, and even biomedicine point to the importance of the professional and user relationship for diagnosis and treatment, with the need to make it more symmetrical, including the patient's word and cultural references, since this erroneously tends to be excluded⁽⁶⁾.

Therefore, incorporating an anthropological view, one should not only see the body of the medical sciences, starting to look at the social construction, in order to understand which therapeutic systems are used to produce knowledge about health. The emphasis in the perspective of the social actor points that, from the

subjects, the possible understanding of practices related to health is built⁽²⁰⁾.

In this sense, one of the major challenges for health professionals is to advance in the approach and understanding of the different perspectives of health self-care, through actions that contemplate the reality of the different territories and that allow professionals to work with the perspective of comprehensive health care. This movement is often limited due to the attachment to the biomedical model, with an exclusive focus on the disease.

FINAL CONSIDERATIONS

The research allowed understanding different actions of self-attention in the family context of students. The health self-care actions in the urban and rural family context occur through a constant articulation between the forms of care including the medicinal plants, the self-medication and the monitoring of symptoms that can be measured or that are in compass with the social values, including access to the local health service.

There is a constant interlocution between care systems, which reaffirms that self-care includes several

interconnected care, not excluding any type, demonstrating that the population does not deny one by using the other, but constantly articulates the practices. However, health professionals are not acting in an articulated way, which is perceived by the population.

Health self-care occurs in its broad and restricted form in the urban and rural environment, in the family environment, without great difference in relation to the provided care, differing only in terms of access to medicinal plants, which is still greater in the rural environment, meeting the assumptions of this research.

In this way, health professionals need to turn their attention constantly to the family care, and to children and adolescents, in order to know the different practices of health self-care, for an articulated and effective care. Thus, health professionals need to approach the population, so that care is not limited to the physical space of health units, since self-care occurs especially in the family environment.

A limitation of the study is the non-inclusion of families of students who reported not using medicinal plants, which represents a need for further studies.

AUTOATENÇÃO EM SAÚDE E O USO DE PLANTAS MEDICINAIS NO CONTEXTO FAMILIAR DE ESCOLARES

RESUMO

Objetivou-se conhecer ações de autoatenção em saúde adotadas no contexto familiar de escolares, do meio urbano e rural e a sua relação com as plantas medicinais. Consistiu em uma pesquisa qualitativa exploratória, fundamentada no referencial de Autoatenção. Os dados foram coletados entre janeiro e julho de 2014, por meio de entrevista semiestruturada gravada no domicílio dos familiares de escolares. A análise foi realizada por meio da Proposta Operativa emergindo os temas: O cuidado com a saúde em ações de autoatenção amplas e Cuidados na prevenção da doença em ações de autoatenção restritas. Os resultados apontam a constante articulação entre as formas de autoatenção ampla e restrita, no meio urbano e rural, incluindo as plantas medicinais, a automedicação, a vigilância de sintomas e consultas em unidades de saúde. Esta interlocução constante reafirma que a autoatenção inclui diversos cuidados interligados, sem excluir nenhum tipo, demonstrando que a população não nega uma por utilizar a outra, e sim articula constantemente as práticas. No entanto, os profissionais da saúde não estão atuando de maneira articulada, o que é percebido pela população. Isto sugere a necessidade destes profissionais considerarem as práticas culturais de cuidado, promovendo a saúde de forma integral e articulada.

Palavras-chave: Família. Relações familiares. Atenção à saúde. Cultura. Saúde escolar.

AUTOATENCIÓN EN SALUD Y EL USO DE PLANTAS MEDICINALES EN EL CONTEXTO FAMILIAR DE ESCOLARES

RESUMEN

Este estudio tuvo el objetivo de conocer las acciones de autoatención en salud adoptadas en el contexto familiar de escolares, del medio urbano y rural y su relación con las plantas medicinales. Consistió en una investigación cualitativa exploratoria, fundamentada en el referencial de Autoatención. Los datos fueron recolectados entre enero y julio de 2014, por medio de entrevista semiestructurada grabada en el hogar de los familiares de escolares. El análisis fue realizado por medio de la Propuesta Operativa emergiendo los temas: El cuidado con la salud en acciones de autoatención amplias y Cuidados en la prevención de la enfermedad en acciones de autoatención restringidas. Los resultados señalan la constante articulación entre las formas de autoatención amplia y restringida, en el medio urbano y rural, incluyendo las plantas medicinales, la automedicación, la vigilancia de síntomas y las consultas en unidades de salud. Esta interlocución constante reafirma que la

autoatención incluye diversos cuidados interconectados, sin excluir ningún tipo, demostrando que la población no niega una por utilizar la otra, sino articula constantemente las prácticas. Sin embargo, los profesionales de la salud no están actuando de manera articulada, lo que se percibe por la población. Esto sugiere la necesidad de que estos profesionales consideren las prácticas culturales de cuidado, promoviendo la salud de forma integral y articulada.

Palabras clave: Familia. Relaciones familiares. Atención a la salud. Cultura. Salud escolar.

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